

March 2016 Standards Manual Changes

Document	Page	Change	Rationale	Practice Changes
Practice Guideline				
End Tidal Capnography in Non-Intubated Patients	1-15.1	New guideline	ETCO ₂ of spontaneously breathing, non-intubated patients allows for early effective detection of hypoventilation possibly resulting from analgesia, sedation, or medical conditions such as sedating overdoses or intoxication.	ETCO ₂ will be applied on non-intubated patients who: receive ketamine; are below age 10 or over age 60 and receive more than 2 doses of fentanyl or midazolam; or whenever clinical judgement determines patient may be altered as a result of EMS administered medication or another medical condition.
Medication List	1-28 – 1-30.03	<p>Added acetaminophen to the list <i>for adult patients only.</i></p> <p>Added additional ketamine dosing for sedating intubated patients with anxiety secondary to the tube.</p> <p>Clarified PO as a route for diphenhydramine only when given as a tablet or capsule</p>	<p>Acetaminophen may be administered for adult patients with sepsis (new protocol).</p> <p>Intubated patients who are no longer comatose may experience agitation due to the tube; sedation may prevent accidental extubation</p> <p>Some venues (BMO Harris Bradley Center and Milwaukee County Zoo carry Benadryl tablets/capsules</p>	<p>Adult septic patients may receive 1 g acetaminophen prior to hospital arrival.</p> <p>Intubated patients may be sedated to prevent accidental extubation.</p> <p>Diphenhydramine may only be administered orally in tablet or capsule form</p>
Traumatic Cardiac Arrest – Sudden	1-45	New criteria established for termination of resuscitation (TOR) in patients with sudden traumatic arrest. Patients with any signs of life are to have lifesaving interventions (LSI) initiated. Once LSI initiated, a medical control order is required to terminate resuscitation attempt. NO ACLS drugs are indicated for these resuscitation attempts.	Evidence indicates traumatic arrests are sometimes terminated or not initiated in patients with possible signs of life.	Patients with any signs of life will have lifesaving interventions initiated.

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Protocol				
ROSC (Return of Spontaneous Circulation) Adult	2-12	New protocol <i>for adult patients only</i> .	Directs treatment for patients resuscitated in the field; along with acquiring and transmitting a post-ROSC 12-lead, providers are to report initial arrest rhythm of VF or VT as the hospital may activate the cath lab based on this information.	Hospitals may receive report of arrest rhythm.
Sedation Following Airway Placement	2-12.1	New protocol for pediatric and adult patients.	Added additional ketamine, fentanyl and midazolam dosing for sedating intubated patients who are no longer comatose. These patients may experience agitation due to the tube; sedation may prevent accidental extubation.	Intubated patients may be sedated to prevent accidental extubation.
Sepsis Syndrome – Adult	2-13.1	New protocol <i>for adult patients only</i> .	Prehospital assessment and advance notification to the receiving ED has been shown to decrease time to diagnosis, reduce treatment times and potentially improve patient outcome. Adult febrile patients suspected of being septic, may receive 1 g acetaminophen if able to safely swallow the tablets. A Code Sepsis alert will be paged to the hospital.	Assessment will focus on Systemic Inflammatory Response Syndrome (SIRS) criteria. Adult febrile patients with suspected sepsis and able to swallow tablets may have 1 g acetaminophen administered prior to arrival. Code Sepsis will be paged to the receiving hospital.
Trauma	2-15	Directs providers to Trauma Arrest – Sudden protocol if patient is in or develops cardiac arrest due to trauma	Protocol directs treatment/transport for patients <i>not</i> in traumatic arrest	Providers will refer to Trauma Arrest – Sudden for patients in traumatic cardiac arrest
Skill				
CPR	3-48.1	Adult CPR standards reverted back to AHA standards with 30:2 compression:ventilation ratio	CPR study has been completed showing no significant advantage to CCC; skill rewritten to reflect current practice of following AHA standard CPR	No change; documentation updated to reflect current practice

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Skill				
Needle Thoracostomy	3-52 – 3-52.1	Transition from standard 14G to 10G angiocath; added a secondary site at the 5 th intercostal space (ICS), midaxillary line (MAL) for ineffective decompression at the primary site.	22-50% of decompressions may be ineffective based on the average chest wall thickness at the 2 nd intracostal space, midclavicular line (MCL) of trauma patients with the shorter smaller needle. The secondary site is generally a thinner area with no major blood vessels, but more challenging to identify.	Providers will use longer, larger bore needle for chest decompression. If 2 nd ICS at MCL attempt is unsuccessful, a second attempt should be made at the 5 th ICS at MAL.
Policy				
Adverse Medical Event Mandatory Reporting	4-1.01-4-1.02	Any significant EMS related event reported to the FD's risk manager or other regulatory agency including, but not limited to, the jurisdictional Fire/Police or Public Safety Commission, OSHA, or WI Department of Health will be reported to MCEMS.	Maintains compliance with DDHS 110.54 Reasons for Enforcement Actions, WI State Statute Chapter 256 or other related Statute, Administrative Rule or Local ordinance.	Significant EMS related events will be reported to MCEMS in the established time line for the type of event.
Alerts – Code STEMI, Code Stroke, Code Isolation, Code Sepsis	4-1.2	Changed Code Infection to Code Isolation Added Code Sepsis	To be more descriptive of hospital needs on patient arrival and decrease confusion between infection and sepsis – still includes suspected infectious agent. Prenotification of a potential septic patient has shown decreased times in diagnosis, treatment, and improved outcome.	Patients requiring isolation measures (measles, bed bugs, TB, etc.) will have a Code Isolation alert with the infectious agent paged out. Patients suspected to be suffering from a systemic infectious response syndrome (SIRS) will have a Code Sepsis alert paged out to the receiving hospital.
HIPAA Compliance and Patient Confidentiality	4-10.04	New policy	MCEMS endorses and expects all EMS providers working under MCEMS medical direction to follow their agency's internal policies and procedures for privacy and security practices and receive HIPAA training.	Any inadvertent, unintentional or negligent act which violates a patient privacy policy must be reported to their agency's privacy officer.
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Policy (cont'd)				
Hospital Destination	4-10.05	New policy	Provides principles and decision-making guidance for patients, EMS providers and hospitals within the MCEMS system.	Internal Disaster is the only EMS system designation recognized by MCEMS as "closing" a hospital to ambulance transport.
Lights and Siren Guidelines with Patient On-board	4-10.21	New policy	Use of warning lights and siren has safety implications to patients, providers and the public; saves very little time based on scientific literature; and should only be used in a truly life-saving or time sensitive emergency.	Use of lights and siren will only be used when the situation warrants the need. Providers will document on the patient care record when lights and siren were activated during transport.
Management of Deceased Patients	4-10.3	Deleted last criteria for not initiating a resuscitation attempt.	Updated to be consistent with the new Traumatic Cardiac Arrest – Sudden practice guideline	Patients with SCA due to trauma will have life sustaining interventions initiated if any ECG activity is detected
Medication Errors	4-11	Directs providers to the Adverse Medical Events Mandatory Reporting Policy after medical control and receiving hospital have been notified of the error.	Reporting of medication errors requires immediate notification of medical control and receiving hospital for patient safety and monitoring purposes. Report to MCEMS should follow time schedule outlined on Adverse Medical Events Mandatory Reporting Policy.	Report to MCEMS to follow new policy.
On-Line Medical Control (OLMC) Guidelines	4-12.1	New policy	Provides guidelines on when OLMC is required and how to handle unusual circumstances.	Providers will contact medical control as outlined in policy.

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Police Body Worn Cameras / Video Recordings	4-15.02	New policy	<p>Community law enforcement agencies are expanding the use of body worn cameras to assist officers in the performance of their duties. Police are neither a HIPAA covered entity nor do they fall under WI patient health care confidentiality laws. Recommendations are to:</p> <ol style="list-style-type: none"> 1. Ensure safety for all on scene. 2. Provide care as usual, protecting patient privacy as possible. 3. Don't interfere with law enforcement's decision to continue filming. 4. Be aware these films are subject to open records laws. 5. Document, document, document! 	Providers may request cameras to be turned off, but the final decision is up to the officer(s).
To Be Deleted				
Amiodarone Lidocaine Placebo Study	6-3	Delete	Study has ended.	Patients will no longer be enrolled in study.

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Initial: 3/1/16
Reviewed/revised:
Revision:

MILWAUKEE COUNTY EMS
PRACTICE GUIDELINE
END TIDAL CAPNOGRAPHY IN
NON-INTUBATED PATIENTS

Approved: M. Riccardo Colella, DO, MPH, FACEP
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End Tidal Capnography (ETCO₂) monitoring of spontaneously breathing, non-intubated patients allows for early effective detection of hypoventilation that may result from analgesia, sedation, or medical conditions such as sedating overdoses or intoxication.

ETCO₂ may be effective in detection of metabolic acidosis causing hyperventilation in conditions such as sepsis.

This policy will focus on ETCO₂ as an adjunct for early assessment of hypoventilation; other applications of ETCO₂ for various medical conditions have been reported but are beyond the scope of this guideline.

Capnography Values

ETCO₂ 35-45 mm Hg is the normal value for capnography.

ETCO₂ Less Than 35 mmHg (HYPOcapnia ↓) suggests hyperventilation.↑

ETCO₂ Greater Than 45 mmHg (HYPERcapnia ↑) suggests hypoventilation.↓

A flat-line ETCO₂ suggests apnea.

POLICY:

- ETCO₂ will be applied on all patients who receive ketamine. Since ketamine often increases respiratory rate, the ETCO₂ value may often be less than 35 mmHg. A rare side effect of ketamine is laryngospasm. The combination of absent chest wall movement and a flat-line waveform differentiates apnea from upper airway obstruction or laryngospasm, both of which manifest chest wall movement. Response to airway alignment maneuvers (e.g., chin lift, jaw thrust) can often distinguish upper airway obstruction from laryngospasm.
- ETCO₂ will be applied on all patients below age 10 and above age 60 who receive more than 2 doses of fentanyl or midazolam. An increasing ETCO₂ trend (greater than 45 mmHg) may indicate early hypoventilation requiring stimulation, airway repositioning, reversal agent, or other airway/ventilation assistance.
- ETCO₂ will be applied on all patients whenever the clinical judgement of the EMS provider feels patient is altered as a result of a medication provided by EMS or from a medical condition being experienced by the patient. An increasing ETCO₂ trend (greater than 45 mmHg) may indicate early hypoventilation requiring stimulation, airway repositioning, reversal agent, or other airway/ventilation assistance.

ETCO₂ values should be clinically correlated.

Initiated: 9/92
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Revision: 29

MILWAUKEE COUNTY EMS
PRACTICE GUIDELINE
MEDICATION LIST

Approved by: M. Riccardo Colella, DO, MPH, FACEP
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POLICY:

- All medications will be administered and documented as outlined in system policy.
- Concentrations and packaging of medications may change depending on availability; adjust volume administered to ensure proper dosing.
- IV/IO bolus should be administered over 10 seconds.
- Slow IV push should be administered over 1 – 2 minutes.

MEDICATION	USUAL ADULT DOSE	USUAL PEDS DOSE	ADMINISTRATION GUIDELINE	MONITOR, REPORT, DOCUMENT	INDICATIONS	CONTRAINDICATIONS
Acetaminophen 500 mg tablets	1 gram (2 tablets) one dose only	N/A	Swallow	Temperature	Sepsis Syndrome	Known liver disease
Adenosine 12 mg in 4 mL Prefilled syringe	12 mg	1 st dose - 0.1 mg/kg 2 nd dose - 0.2 mg/kg Max dose 12 mg	Rapid IV/IO	Continuous ECG Attempt to record conversion	Narrow complex tachycardia	Heart block Heart transplant Resuscitated PNB
Albuterol/ Ipratropium (Ventolin/ Atrovent) 2.5 mg albuterol / 0.5 mg ipratropium in 3 mL unit dose	5 mg albuterol /1 mg ipratropium in 3 mL, Max dose 15 mg albuterol/ 3 mg ipratropium	2.5 mg albuterol / 0.5mg ipratropium in 3 mL Max dose 7.5 mg albuterol/ 1.5 mg ipratropium	Nebulized; Do not dilute	Patients with cardiac history over the age of 60 will have ECG monitoring during administration Heart rate Change in respiratory status	Respiratory distress	Heart rate >180
Amiodarone (Cordarone) 150 mg in 3 mL Carpject	300 mg ----- 150 mg add to 100 mL D5W	5mg/kg ----- 5mg/kg add to 100 mL D5W, Max dose 300 mg	IV/IO bolus ----- IV/IO drip, run over 10 minutes	ECG changes Blood pressure	Cardiac arrest ----- Wide complex tachycardia	2 nd or 3 rd degree AV block, Bradycardia Not to be administered via ETT
Aspirin 81 mg Chewable tablet	324 mg - 4 tablets	N/A	Chew and swallow	N/A	Angina / acute coronary syndrome	Allergy

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MILWAUKEE COUNTY EMS
PRACTICE GUIDELINE
MEDICATION LIST

Approved by: M. Riccardo Colella, DO, MPH, FACEP
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MEDICATION	USUAL ADULT DOSE	USUAL PEDS DOSE	ADMINISTRATION GUIDELINE	MONITOR, REPORT, DOCUMENT	INDICATIONS	CONTRAINDICATIONS
Atropine 1mg in 10 mL Prefilled	0.5 - 1 mg Minimum dose 0.1 mg Max dose 0.04 mg/kg or 3 mg	0.02 mg/kg Minimum dose 0.1 mg Max dose 1 mg	IV/IO	Heart rate before and after administration; BP within 5 minutes of administration; ECG changes	Bradycardia	Tachycardia
	2 mg	0.4 mg/kg	ET			
	2 - 5 mg	0.5 mg/kg	IV/IO			
Calcium Gluconate 1g in 10mL Single dose vial	3 g Max dose 3g	60 mg/kg Max dose 3000mg	IV/IO Push over 2-5 minutes	ECG changes Watch carefully for infiltration Bradycardia	Suspected hyper- kalemia in cardiac arrest; As directed by medical control	Ventricular fibrillation Ventricular tachycardia
D5 in Water 100 mL bag	Used to dilute amiodarone, sodium bicarbonate	Used to dilute dextrose and sodium bicarbonate		Monitor for infiltration Monitor pediatric blood glucose levels		None
Dextrose 25 g in 50 mL Prefilled	25 g	500 mg/kg (2 ml/kg of diluted solution) to a max of 25 g/dose	IV bolus or swallowed <i>IO in cardiac arrest</i> Dilute 1:1 with D5W for patients less than 100 lbs/45 kg	Changes in level of consciousness Repeat blood sugar determination Watch carefully for infiltration	Hypoglycemia	If hypoglycemic, no Contraindications

Initiated: 9/92
Reviewed/revised: 3/1/16
Revision: 29

MILWAUKEE COUNTY EMS
PRACTICE GUIDELINE
MEDICATION LIST

Approved by: M. Riccardo Colella, DO, MPH, FACEP
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MEDICATION	USUAL ADULT DOSE	USUAL PEDS DOSE	ADMINISTRATION GUIDELINE	MONITOR, REPORT, DOCUMENT	INDICATIONS	CONTRAINDICATIONS
Diphenhydramine (Benadryl) 50 mg in 1 mL, 25 mg pills	25 – 50 mg	1 mg/kg Max dose 25 mg	IV/IO Push, IM Swallow for pills only	Changes in level of consciousness	Anaphylaxis	Presence of a self-administered CNS depressant
Dopamine 200 mg in 250 mL Premixed IV	2 – 20 mcg/kg/min	2 – 20 mcg/kg/min	IV/IO drip	ECG changes Headache Watch carefully for infiltration	Hypotension	Hypovolemic shock Ventricular fibrillation, Ventricular tachycardia or PVCs
DuoDote Kit Atropine 2.1 mg/0.7 mL Pralidoxine 600 mg/2 mL Autoinjector	Atropine – 2 mg IM Pralidoxine – 600 mg IM	N/A	IM autoinjectors	Change in symptoms Change in level of consciousness	Chemical exposure	Mild symptoms with no miosis
Epinephrine <u>1:1000</u> – 1 mg in 1 mL vial	0.3 mg (greater than 30 kg) or adult autoinjector	0.15 mg (less than 30 kg) or pediatric autoinjector	IM, or autoinjector (Vastus lateralis preferred site)	Breath sounds and vital signs within 5 minutes of administration Effect on heart rate ECG changes	Anaphylaxis	No absolute contraindications in a life-threatening situation Use caution when administering to patient with hypertension or coronary artery disease
	0.5 - 1 mg 2 mg	0.01 mg/kg 0.1 mg/kg	IV/IO ET		Cardiac arrest	
Epinephrine <u>1:10,000</u> 1 mg in 10 mL Prefilled	0.1 mg/kg	0.01 mg/kg Max dose 1 mg	IV/IO	Breath sounds and vital signs within 5 minutes of administration Effect on heart rate ECG changes	Refractory anaphylaxis	No absolute contraindications in a life-threatening situation Use caution when administering to patient with hypertension or coronary artery disease
	0.5 – 1mg	IV/IO – 0.01mg/kg Max dose 1 mg	IV/IO		Cardiac arrest	
	2 mg ET	0.1 mg/kg Max dose 1 mg	ET		Cardiac arrest	

Initiated: 9/92
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Revision: 29

MILWAUKEE COUNTY EMS
PRACTICE GUIDELINE
MEDICATION LIST

Approved by: M. Riccardo Colella, DO, MPH, FACEP
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MEDICATION	USUAL ADULT DOSE	USUAL PEDS DOSE	ADMINISTRATION GUIDELINE	MONITOR, REPORT, DOCUMENT	INDICATIONS	CONTRAINDICATIONS
Fentanyl 100 mcg/ 2 mL Carpject/tubex	1 mcg/kg Max single dose 100 mcg	0.5 – 1mcg/kg Max single dose 50 mcg	IV/IO Push, IM, IN	Change in pain level Changes in respiratory rate and effort Capnography	Pain management	Respiratory depression GCS < 14 Hypotension
	0.5 mcg/kg Max single dose 100 mcg	0.5 mcg/kg Max single dose 50 mcg	IV/IO Push	Agitation post airway placement	Sedation post airway placement	
Glucagon 1 mg with 1 mL diluting solution	1 mg	1 mg	IM, IN	Level of consciousness Repeat blood glucose determination	Hypoglycemia	Known hypersensitivity Known pheochromocytoma
Glucose (oral) 15 g in 37.5 g Gel tube	15g	15g	Swallowed	Level of consciousness	Hypoglycemia	Lack of gag reflex Patient unable to swallow
Hydroxocobalamin (CYANOKIT®) (1) 5 g vial Reconstitute with 200 mL saline or D5W	5 g IV/IO drip	70 mg/kg Max dose 5 g	IV/IO drip infused wide open over 15 minutes	Blood pressure Nausea Headache Site reactions Rash	Cyanide poisoning	None
Ketamine 500 mg in 5 mL Vial	1 mg/kg; max dose 100 mg	1 mg/kg IV; max dose 100 mg	IV; dilute 1:1 with NS	Heart rate and rhythm Blood pressure	Excited delirium;	Hydrocephalus Allergy
	3 mg/kg max dose 300 mg	3 mg/kg max dose 300 mg	IM; do not dilute	Level of consciousness / hallucinations Excessive salivation Respiratory rate	Immediate threat of harm to self or others	
	0.3 mg/kg	0.3mg/kg	IV/IO	Capnography	Sedation	
Lidocaine (Xylocaine) 20 mg/mL in 5 ml vial	1 mg/kg Max dose 40 mg	1mg/kg Max dose mg	IO Push	ECG changes	Pain management in conscious patients with IO insertion	Heart block Junctional arrhythmia Brady arrhythmia

Initiated: 9/92
Reviewed/revised: 3/1/16
Revision: 29

**MILWAUKEE COUNTY EMS
PRACTICE GUIDELINE
MEDICATION LIST**

Approved by: M. Riccardo Colella, DO, MPH, FACEP
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MEDICATION	USUAL ADULT DOSE	USUAL PEDS DOSE	ADMINISTRATION GUIDELINE	MONITOR, REPORT, DOCUMENT	INDICATIONS	CONTRAINDICATIONS
Midazolam (Versed) 5 mg in 5 mL vial	1 - 4 mg Max dose 4 mg	0.1mg/kg Max dose 2 mg	IV/IO Push, IN, rectal	Changes in respiratory rate and effort Changes in level of consciousness and seizure activity Capnography Agitation post airway placement	Chemical restraint Seizure	Hypotension Presence of a self-administered CNS depressant
	10 mg Max 10 mg	0.25 mg/kg Max 5 mg	IM			
	0.1 mg/kg Max 2 mg	0.1 mg/kg Max 2 mg	IV/IO			
Naloxone (Narcan) 2 mg in 2 mL Prefilled	0.5 mg	0.1 mg/kg Max single dose 0.5 mg	IV/IO bolus, ET, IM, IN	Change in level of consciousness	Narcotic overdose	Allergy
Nitroglycerin Metered spray canister – 0.4 mg/spray	0.4 mg	N/A	Sublingual metered spray	Blood pressure prior to and after administration Headache	Angina / acute coronary syndrome/ CHF	Hypotension Use of Viagra-like medication (phosphodiesterase inhibitor) within last 72 hours
Normal Saline 1000 mL, 250mL bags, 2mL carpuject	As needed for volume replacement or to administer medications	20 mL/kg	fluid bolus	Label date and time set up assembled Document mL of fluid infused Blood pressure Monitor for infiltration Attempt to keep warm in extreme cold	Fluid replacement	Discard after 24 hours or if no longer sterile
Ondansetron (Zofran) 4 mg oral dissolving tablets	Over 30 kg: 8 mg	15 – 30 kg: 4 mg	oral dissolving tablet	Headache Dizziness Dysarthria	Nausea/ vomiting	Prolonged QT complex: Male: greater than 450 ms Female: greater than 470 ms
Ondansetron 2 mg/mL in 2 mL vial	0.1 mg/kg–max 4 mg	0.1 mg/kg - max 4 mg	IV/IO Push	Headache Dizziness Dysarthria	Nausea/ vomiting	Prolonged QT complex: Male: greater than 450 ms Female: greater than 470 ms

Initiated: 9/92
Reviewed/revised: 3/1/16
Revision: 29

MILWAUKEE COUNTY EMS
PRACTICE GUIDELINE
MEDICATION LIST

Approved by: M. Riccardo Collella, DO, MPH, FACEP
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MEDICATION	USUAL ADULT DOSE	USUAL PEDS DOSE	ADMINISTRATION GUIDELINE	MONITOR, REPORT, DOCUMENT	INDICATIONS	CONTRAINDICATIONS
Sodium Bicarbonate 50 mEq in 50 mL Prefilled	0.5 - 1 mEq/kg	1 mEq/kg	IV/IO Bolus; dilute for infants 5 kg and less 1:1 with D5W	Change in level of consciousness ECG changes if given for tricyclic OD	Acidosis; Tricyclic OD	Do not mix with epinephrine or dopamine

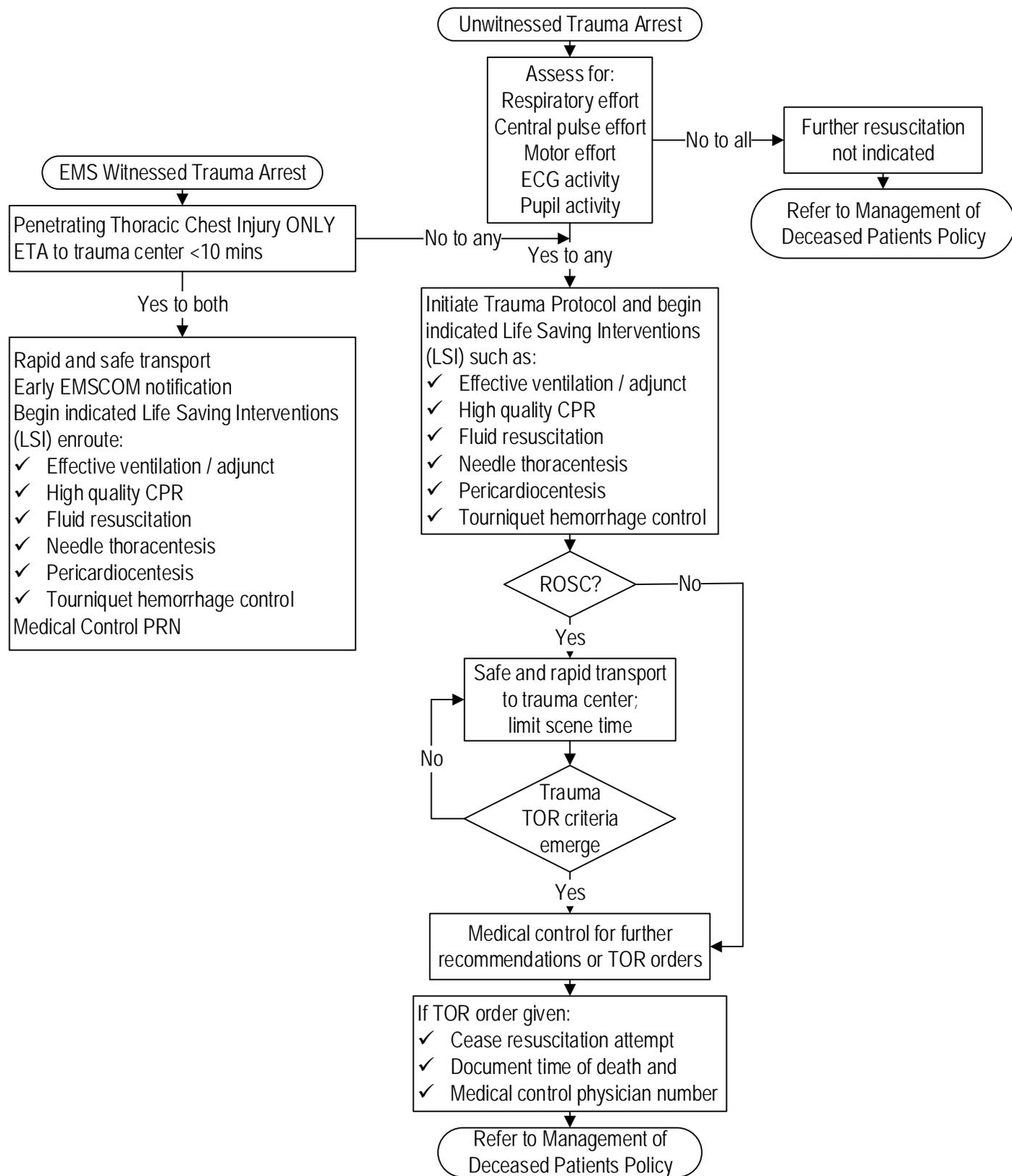
Dopamine Drip Rate Chart – based on standard premixed solution of 200 mg/250 mL, using microdrip tubing (60 gtt/min/mL)

Formula: Amount to give (mcg) X weight (kg) X drip factor ÷ amount on hand (mcg/mL)

Example: Start a dopamine drip at 7.5 mcg on a patient who weighs 176 lbs, using standard premixed dopamine (200 mg/250 mL or 800 mcg/mL)

$$\frac{7.5 \text{ mcg} \times 80 \text{ kg} \times 60 \text{ gtt/min/mL}}{800 \text{ mcg/mL}} = \frac{36000}{800} = 45 \text{ gtt/min}$$

	lbs: 99	110	121	132	143	154	165	176	187	198	209	220
	kg: 45	50	55	60	65	70	75	80	85	90	95	100
Dose: 1 mcg/kg/min	4	4	4	5	5	5	6	6	6	7	7	8
2.5	8	9	10	11	12	13	14	15	16	17	18	19
5	17	19	21	23	24	26	28	30	32	34	36	38
7.5	25	28	31	34	37	39	42	45	48	51	53	56
10	34	38	41	45	49	53	56	60	64	68	71	75
15	51	56	62	68	73	79	84	90	96	101	107	113
20	68	75	83	90	98	105	113	120	128	135	143	150
25	84	94	103	113	122	131	141	150	159	169	178	189
30	101	113	124	135	146	158	169	180	191	203	214	225
35	118	131	144	158	171	184	197	210	223	236	249	263
40	135	150	165	180	195	210	225	240	255	270	285	300
45	152	169	186	203	219	236	253	270	287	304	321	338
50	169	188	206	225	244	263	281	300	319	338	356	375



Initiated: 3/1/16
Reviewed/revised:
Revision:

**MILWAUKEE COUNTY EMS
PRACTICE GUIDELINE
TRAUMATIC CARDIAC
ARREST - SUDDEN**

Approved by: M. Riccardo Colella, DO, MPH, FACEP
Page 2 of 2

NOTES:

- **NO ACLS drugs indicated** (epi, amiodarone, calcium, bicarb) unless ordered by medical control.

Termination of Resuscitation (TOR) Criteria for Traumatic Arrest:

- Less than 20 weeks pregnant (fundus at umbilical height)
- Not believed related to environmental hypothermia
- High quality CPR unsuccessful
- Life Saving Interventions (LSI) unsuccessful
- ETCO₂ 10 mm Hg or less
- No agonal breaths
- No central pulses
- No muscle movement
- No ECG activity
- Fixed, non-reactive pupils

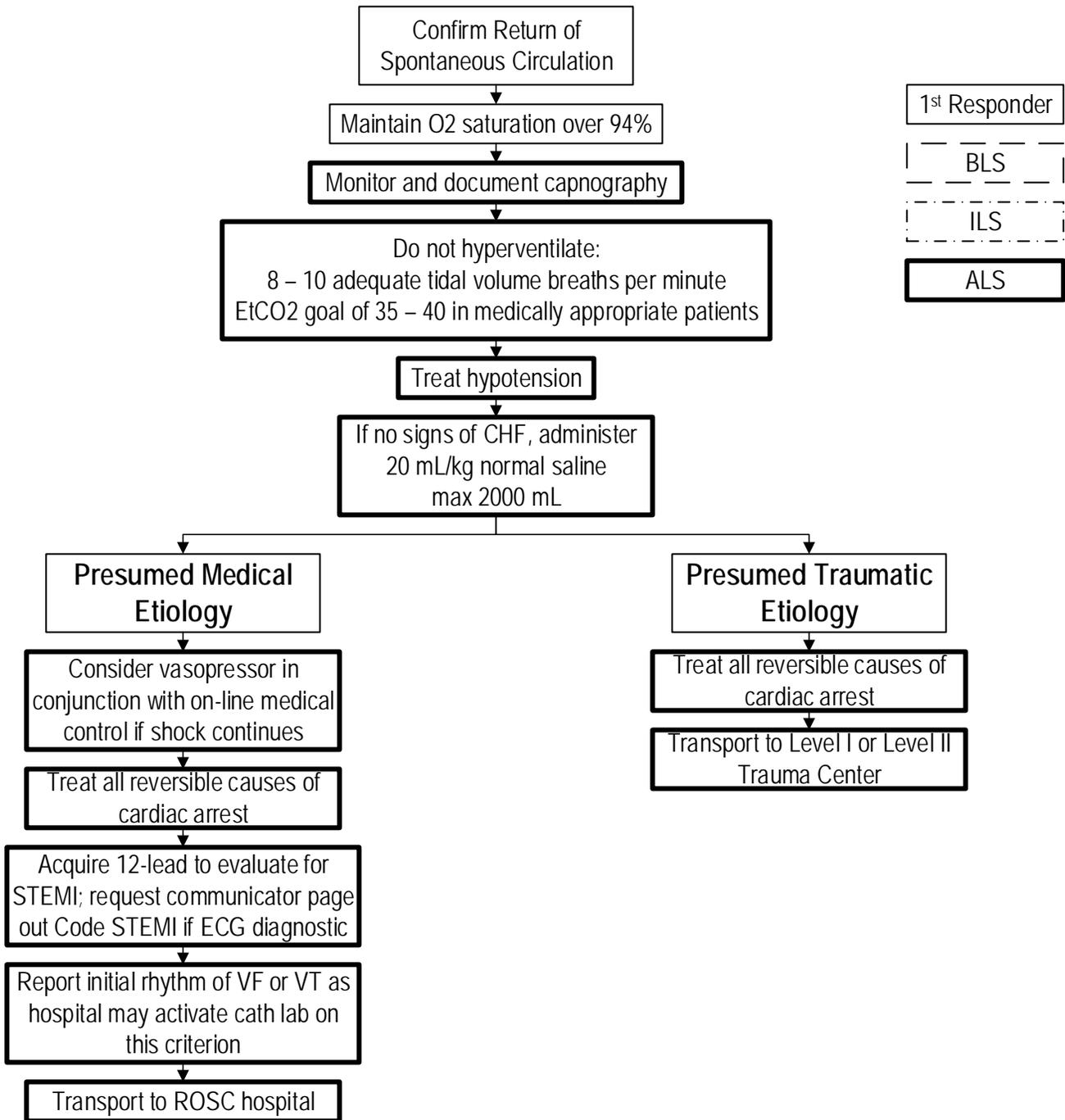
Trauma Arrest LSI and Decision to Transport Summary Matrix

Mechanism	Site	TOR Criteria Met?	Start LSI?	Call Med Control?	Transport to Trauma Center?
Penetrating	Thoracic chest or back; above abdomen	No	Yes	Yes	Perhaps if time from arrest to DELIVERY at trauma center is absolutely <10 min. Logistically, this would be an exceptionally rare occurrence.
Penetrating	Multi-site	No	Yes	Yes	Transport generally not recommended unless ROSC develops.
Blunt	Any	No	Yes	Yes	Transport generally not recommended unless ROSC develops.

Initiated: 3/1/16
Reviewed/revised:
Revision:

**MILWAUKEE COUNTY EMS
MEDICAL PROTOCOL
RETURN OF SPONTANEOUS
CIRCULATION (ROSC) - ADULT**

Approved: M. Riccardo Colella, DO, MPH, FACEP
WI EMS Approval:
Page 1 of 1

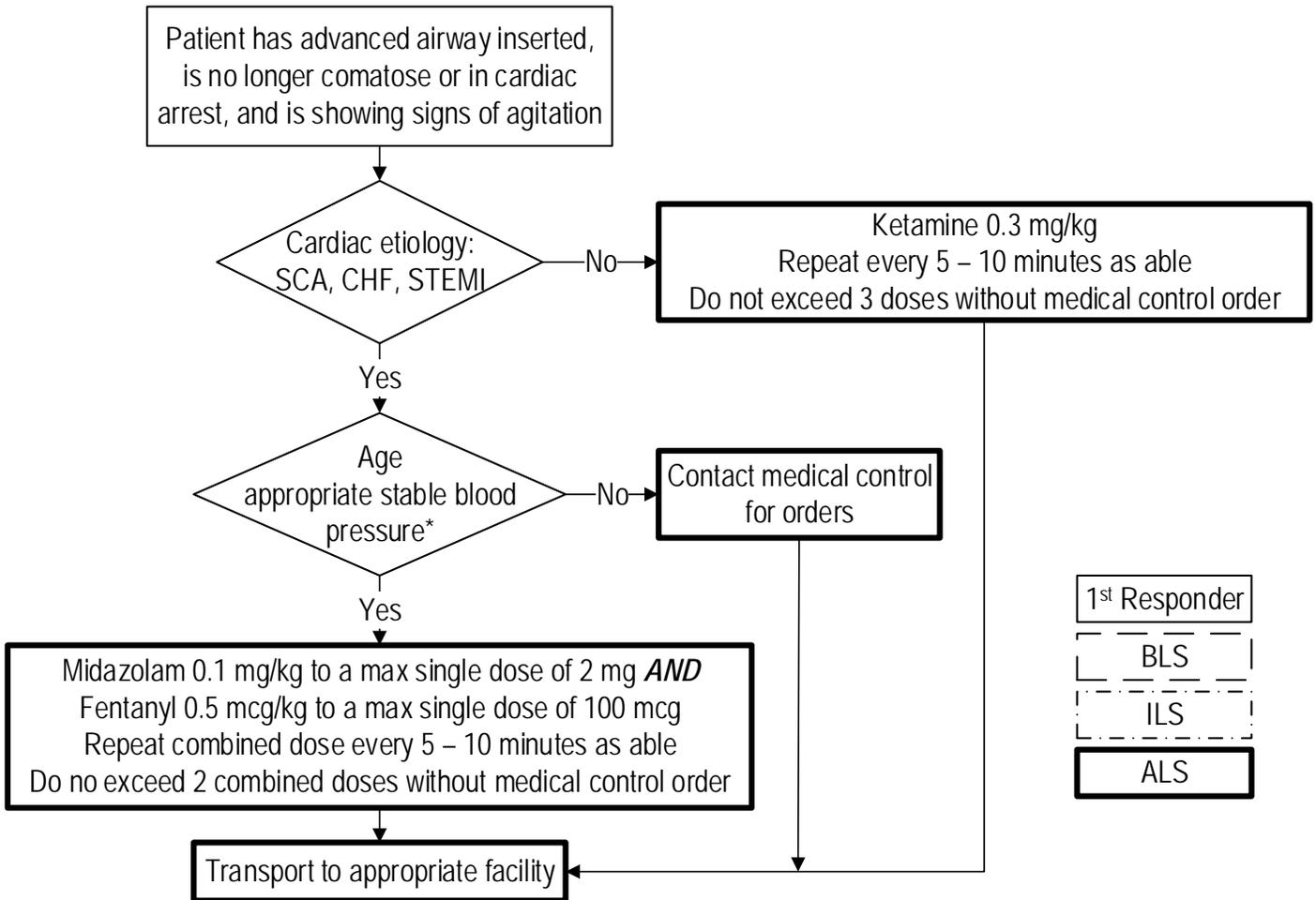


Initiated: 3/1/16
Reviewed/revised:
Revision:

**MILWAUKEE COUNTY EMS
MEDICAL PROTOCOL
SEDATION FOLLOWING
AIRWAY PLACEMENT**

Approved by: M. Riccardo Colella, DO, MPH, FACEP
WI EMS Approval:
Page 1 of 1

History: Recent placement of advanced airway with signs of agitation as a result	Signs/Symptoms: No longer comatose Bucking the airway Increased heart rate Tearing Patient movement
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Notes:

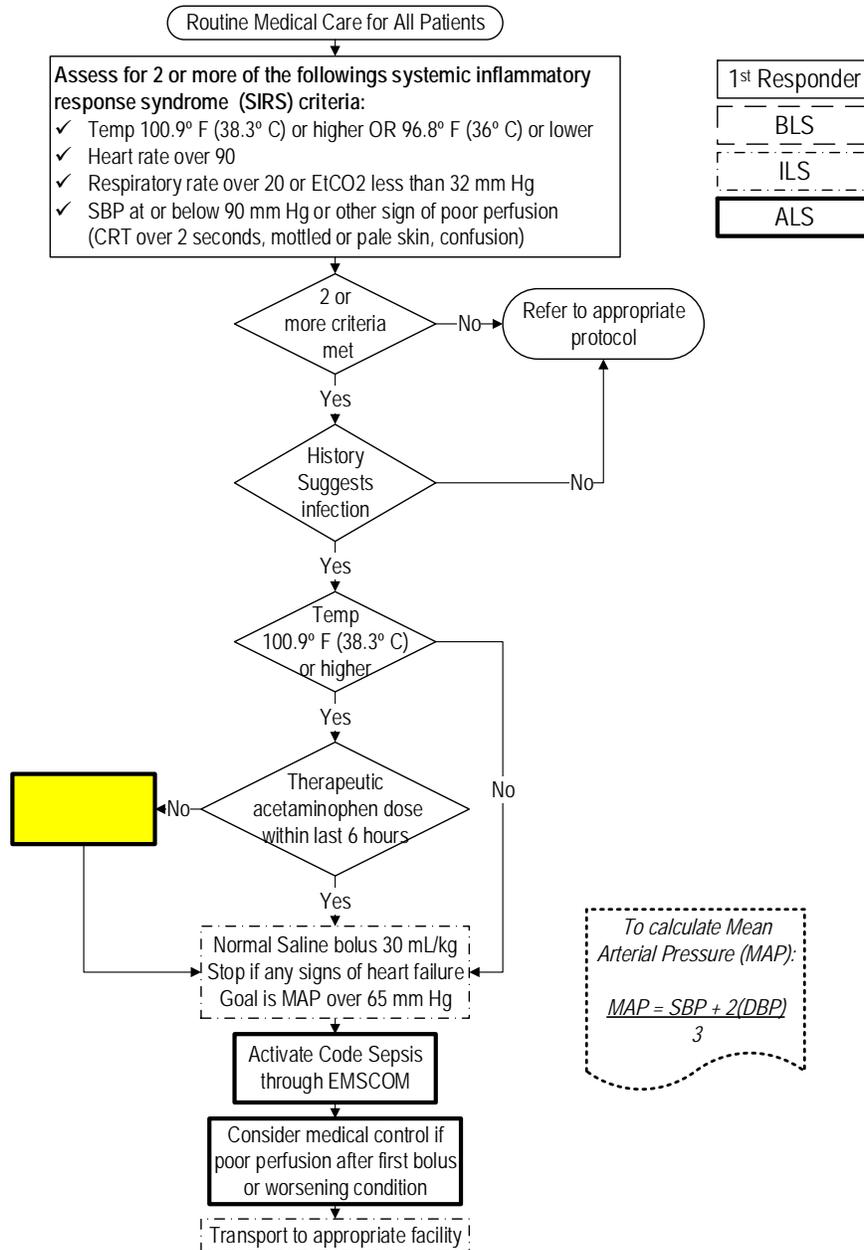
- Age appropriate blood pressure:
 - Adult – over 90 systolic
 - Pediatric – over 70 + (2 x age) up to 90 mm Hg
- SCA = Sudden Cardiac Arrest; CHF = Congestive Heart Failure; STEMI = ST segment Elevation Myocardial Infarction

Initiated: 3/1/16
Reviewed/revised:
Revision:

**MILWAUKEE COUNTY EMS
MEDICAL PROTOCOL
SEPSIS SYNDROME - ADULT**

Approved by: M. Riccardo Colella, DO, MPH, FACEP
WI EMS Approval:
Page 1 of 1

History:		Signs/Symptoms May Include:
Pneumonia	Immunocompromised	Fever/hypothermia
Urinary tract infection	Transplant	Tachycardia
Wound infection	HIV	Tachypnea
CNS infection	Diabetes	Altered mental status
GI Infection (abdominal pain and/or diarrhea)	Cancer	Significant edema
Blood stream or catheter infection	Adult – 18 years or older	Hyperglycemia in non-diabetic patient
Presence of indwelling catheters or devices		



Notes:

- Ensure appropriate PPE
- Also consider blood glucose over 140 in a non-diabetic patient as a sign of sepsis.

Initiated: 12/10/82
 Reviewed/ revised: 3/1/16
 Revision: 15

**MILWAUKEE COUNTY EMS
 MEDICAL PROTOCOL
 TRAUMA**

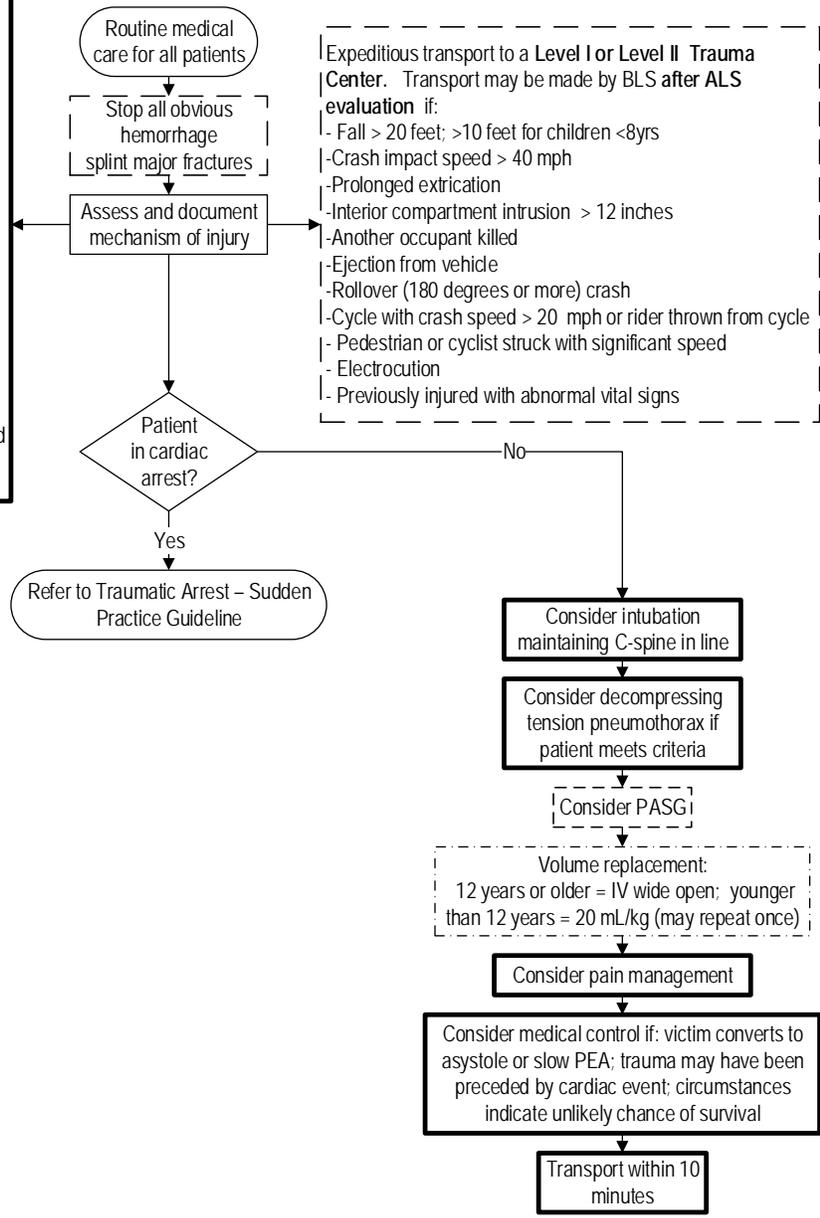
Approved: M. Riccardo Colella, DO, MPH, FACEP
 WI EMS Approval Date: 2/15/12
 Page 1 of 1

Expeditious ALS transport to a Level I or Level II Trauma Center if:

- GCS < 14
- Systolic BP: >8 yrs < 90; 5 - 8 yrs <80; 6 mo - 5 yrs <70; 0-6 mo <60
- Resp. rate: >8 yrs <10 or >29; 6 mo - 8 yrs <16; 0-6 mo <20; respiratory distress (ineffective breathing, grunting or stridor) in children <8 yrs
- Penetrating trauma to head or torso
- Flail chest
- Burns with trauma
- 2+ long bone fractures
- Amputation above wrist/ankle
- New onset of paralysis due to trauma
- Open or depressed skull fracture
- Pelvic fracture
- Distended or rigid abdomen
- Hypothermia from immersion or suspected exposure with above vital signs
- Tourniquet applied to any extremity

Expeditious transport to a Level I or Level II Trauma Center. Transport may be made by BLS after ALS evaluation if:

- Fall > 20 feet; >10 feet for children <8yrs
- Crash impact speed > 40 mph
- Prolonged extrication
- Interior compartment intrusion > 12 inches
- Another occupant killed
- Ejection from vehicle
- Rollover (180 degrees or more) crash
- Cycle with crash speed > 20 mph or rider thrown from cycle
- Pedestrian or cyclist struck with significant speed
- Electrocution
- Previously injured with abnormal vital signs



1st Responder
 BLS
 ILS
 ALS

NOTES:

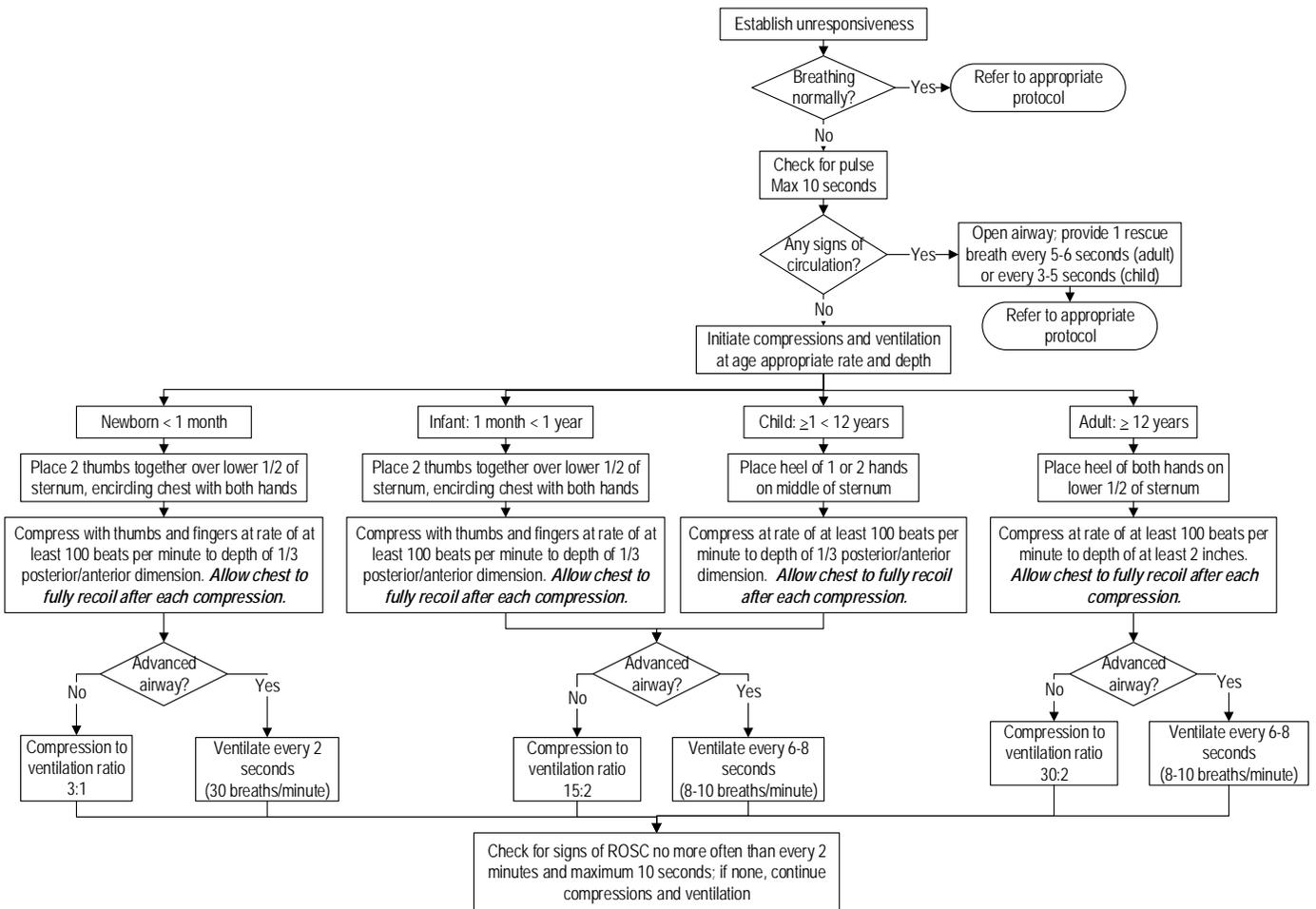
- In all patients with trauma-related cardiac arrest, establish the probable cause of the arrest.
- Resuscitation must be initiated on all patients with ECG activity. Patients in ventricular fibrillation or ventricular tachycardia should be defibrillated once.
- If resuscitation is not attempted based on the PFR or MED unit's interpretation of the ECG rhythm, the PFR or ALS team must complete the appropriate portion of the record.
- Apply pelvic splint or inflate pneumatic antishock garment (PASG) for patients with suspected pelvic fracture.
- Notify EMS Communications of the circumstances of the transport, ETA, and include adequate information to facilitate Trauma Team activation.
- Only reason to consider transport to the closest receiving hospital other than a trauma center is for the inability to ventilate the patient.

Initial: 12/11/02
 Reviewed/revised: 3/1/16
 Revision: 7

MILWAUKEE COUNTY EMS
 PRACTICAL SKILL
CARDIOPULMONARY
RESUSCITATION

Approved by: M. Riccardo Colella, DO, MPH, FACEP
 Page 1 of 1

Purpose: To attempt to establish return of spontaneous circulation and respiration in a patient in cardiorespiratory arrest.		Indications: Patient is in cardiorespiratory arrest.	
Advantages: Provides circulation and respiration during cardiorespiratory arrest	Disadvantages: None	Complications: Possible chest trauma	Contraindications: Patient has pulse and respiration Patient meets any of the following criteria: valid DNR or POLST order, decapitation, rigor mortis, extreme dependent lividity, tissue decomposition, fire victim with full thickness burns to 90% or greater body surface area, or patient meets hypothermia criteria for withholding resuscitative measures



NOTES:

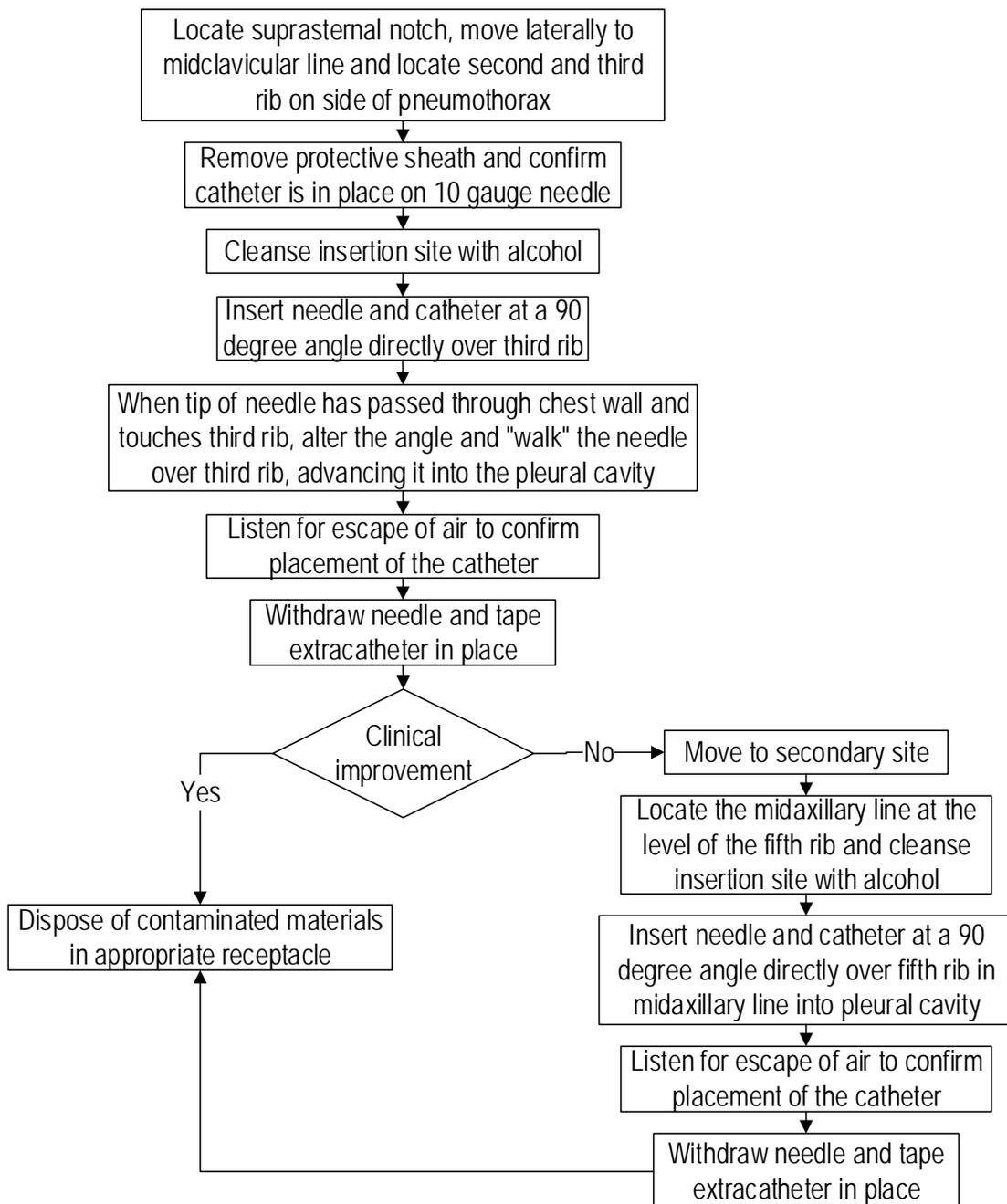
- Placement of an advanced airway should be deferred until 3 cycles of CPR have been administered (approximately 6 minutes).
- The rescuer performing chest compressions should switch at least every 2 minutes.
- All ventilations should be 1 second in duration.
- Chest compressions should be done as follows: **push hard and fast, release completely, minimize interruptions.**
- The system goal is hands on chest more than 90% of time; minimum compression depth of 2 inches in adults 90% of the time.
- The risk and benefit of providing CPR in a moving vehicle must be weighed on a case by case basis.
 - Providing compressions in a moving vehicle exposes the rescuer to potential injury.
 - Chest compressions in a moving vehicle are known to be less effective.

Initial: 9/92
 Revised: 3/1/16
 Revision: 4

**MILWAUKEE COUNTY EMS
 PRACTICAL SKILL
 NEEDLE THORACOSTOMY**

Approved: M. Riccardo Colella, DO, MPH, FACEP
 Page 1 of 2

Purpose: To provide an open vent into the pleural space to decompress suspected tension pneumothorax		Indications: Patients presenting with suspected tension pneumothorax
Advantages: Decompress tension pneumothorax Facilitate ventilation	Complications: Vascular injury Iatrogenic pneumothorax Abdominal perforation/Solid organ injury Cardiac injury	Contraindications: None if patient meets clinical criteria

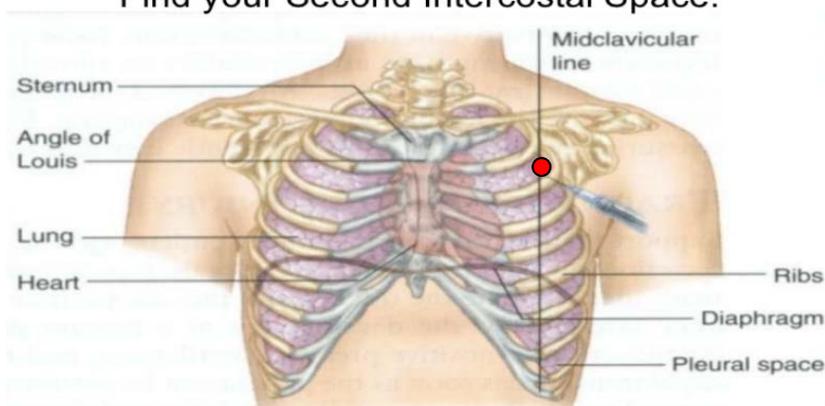


Initial: 9/92
Revised: 3/1/16
Revision: 4

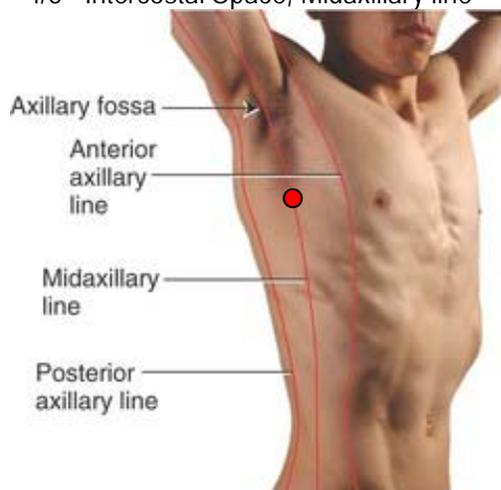
NOTES:

- *Signs/symptoms of a tension pneumothorax:* restless/agitated; increased resistance to ventilation; jugular vein distention; severe respiratory distress; decreased or absent breath sounds on the affected side; hypotension; cyanosis; tracheal deviation away from the affected side; subcutaneous emphysema
- *Indications that procedure was successful:* increase in blood pressure; loss of jugular vein distention; decreased dyspnea; easier to ventilate patient; improved color; improved mental status
- *Landmarks*
 - Primary Site – 2nd Intercostal Space, Midclavicular line

Find your Second Intercostal Space.



- Secondary Site – 4/5th Intercostal Space, Midaxillary line



▪ **PEARLS**

- 4th ICS is at the level of the nipple in a healthy adult male
- 4th ICS may be higher than nipple level of women and obese patients due to breast tissue
- Err on being too high, than too low in placement to avoid abdominal perforation

Initial: 3/1/16
Reviewed/revised:
Revision:

**MILWAUKEE COUNTY EMS
OPERATIONAL POLICY
ADVERSE MEDICAL EVENT
MANDATORY REPORTING**

Approved: M. Riccardo Colella, DO, MPH, FACEP
Page 1 of 2

POLICY: Adverse medical events will be reported to Milwaukee County EMS in the established timeline for the type of event.

Event Type	Sentinel Event / Serious Safety Event	Precursor Safety Event	Serious Circumstances that may impact medical practice within the MCEMS system
Definition	<p>A patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in any of the following:</p> <ul style="list-style-type: none"> ➤ Death ➤ Permanent harm ➤ Severe temporary harm 	<p>Any deviation from the MCEMS standards that reached a patient and had either minimal harm or no harm</p>	<p>Any significant EMS related event report to the fire department's risk manager or other regulatory agency including, but not limited to, the jurisdictional Fire/Police or Public Safety Commission, Occupational Safety and Health Administration, or Wisconsin Department of Health.</p>
Examples include but not limited to	<ul style="list-style-type: none"> ➤ Any deviation from an EMS policy or treatment protocol with patient harm ➤ Medication or procedural errors with harm 		<p>Any of the occurrences defined by DHS 110.54 Reasons for Enforcement Actions, Wisconsin State Statute Chapter 256 or other related Statute, Administrative Rule or local ordinance. Examples include but not limited to:</p> <p>The person made a false statement on an application for, or otherwise obtained a permit, certificate or license through fraud or error.</p> <p>The licensing examination for the person was completed through error or fraud.</p> <p>The person violated a court order pertaining to emergency medical services.</p> <p>The person's license or certification was revoked within the past two years.</p> <p>The person has an arrest or conviction history substantially related to the performance of duties as an EMS professional, as determined by the department.</p> <p>The person committed or permitted, aided or abetted the commission of an unlawful act that substantially relates to performance of EMS duties, as determined by the department.</p> <p>The person failed to a violation of the rules of DHS 110 by a licensee, certificate holder or permit holder.</p> <p>The person failed to maintain certification in CPR for health care professionals by completing a course approved by the department and has performed as a first responder or EMT.</p> <p>The person practiced beyond the scope of practice for his or her license or certificate.</p> <p>The person practiced or attempted to practice when unable to do so with reasonable skill and safety.</p>

Initial: 3/1/16
Reviewed/revised:
Revision:

**MILWAUKEE COUNTY EMS
OPERATIONAL POLICY
ADVERSE MEDICAL EVENT**

Approved: M. Riccardo Colella, DO, MPH, FACEP
Page 2 of 2

Event Type	Sentinel Event / Serious Safety Event	Precursor Safety Event	Serious Circumstances that may impact medical practice within the MCEMS system
			<p>The person practiced or attempted to practice while impaired by alcohol or other drugs.</p> <p>The person engaged in conduct that was dangerous or detrimental to the health or safety of a patient or to members of the general public while performing EMS duties.</p> <p>The person administered, supplied, obtained or possessed any drug other than in the course of legitimate EMS practice or as otherwise permitted by law.</p> <p>The individual engaged in inappropriate sexual contact, exposure, gratification, or other sexual behavior with or in the presence of a patient.</p> <p>The person abused a patient by any act of nonconsensual force, violence, harassment, deprivation, nonconsensual sexual contact or neglect.</p> <p>The person obtained or attempted to obtain anything of value from a patient for the benefit of self or a person other than the patient unless authorized by law.</p> <p>The person falsified or inappropriately altered patient care reports.</p> <p>The person revealed to another person not engaged in the care of the patient information about a patient's medical condition when release of the information was not authorized by the patient, authorized by law, or requested by the department in the investigation of complaints.</p> <p>The person failed or refused to provide emergency medical care to a patient because of the patient's race, color, sex, age, beliefs, national origin, handicap, medical condition, or sexual orientation.</p> <p>The person abandoned a patient.</p>
Note	Anything event that has patient harm, implicates MCEMS or partnering fire departments and is likely to be a news/media story within 24 hours.		
Timing	Immediate	Within next business day	Within next business day
Whom to contact	Medical Director 24/7 via EMSCOM Quality Manager during business hours	Medical Director Quality Manager	Medical Director Quality Manager

Initial: 11/4/13
 Revised: 3/1/16
 Revision: 2

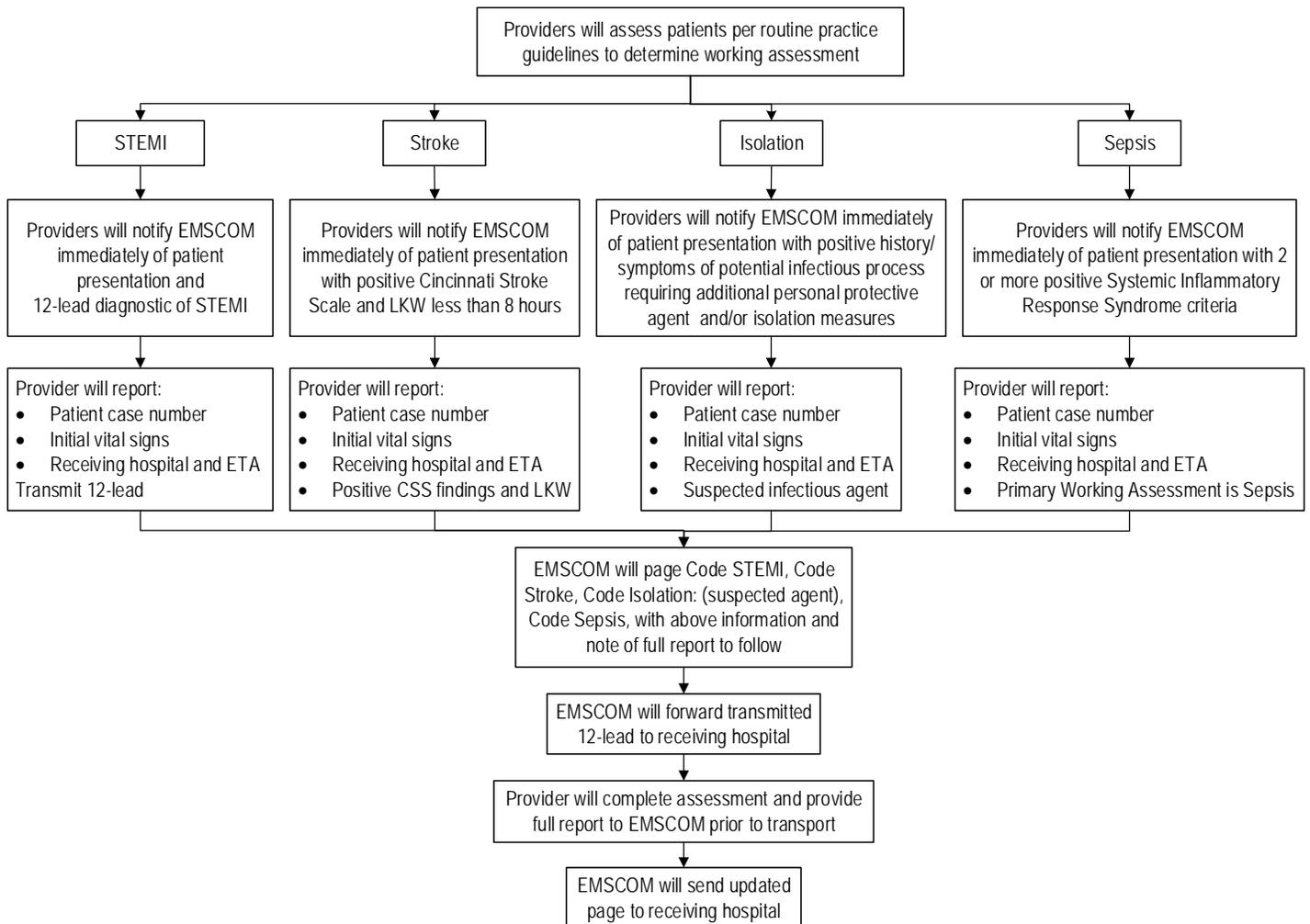
MILWAUKEE COUNTY EMS
 OPERATIONAL POLICY
ALERTS – CODE STEMI, CODE
 STROKE, CODE ISOLATION, CODE SEPSIS

Approved: M. Riccardo Colella, DO, MPH, FACEP
 Page 1 of 1

POLICY:

Milwaukee County EMS Communications will provide early notification of the impending arrival of patients with the following working assessments:

- Suspected STEMI as identified by patient presentation and a diagnostic 12-lead reading ***STEMI***
- Suspected stroke as identified by a positive Cincinnati Stroke Scale and last known well (LKW) time less than 8 hours
- Suspected infectious process requiring additional personal protective equipment or isolation measures
- Suspected sepsis due to an underlying infectious process



Early notification will enable hospitals to review the pre-arrival information and make internal response decisions based on the information forwarded by the field providers and EMSCOM.

Initiated: 3/1/16
Reviewed/revised:
Revision:

**MILWAUKEE COUNTY EMS
OPERATIONAL POLICY
HIPAA COMPLIANCE AND
PATIENT CONFIDENTIALITY**

Approved by: M. Riccardo Colella, DO, MPH, FACEP
Page: 1 of 1

POLICY: Federal legislation and Wisconsin “confidentiality” laws rigorously protect patient health information. Both federal and State regulations must be followed to ensure patient privacy protection.

All EMS Provider agencies that are considered covered entities under the federal Health Insurance Portability and Accountability Act of 1996 (45 C.F.R. parts 160 & 164) are required to become and maintain compliance with the HIPAA Privacy Rule, Security Rule and Electronic Data Exchange regulations. All Fire Departments in Milwaukee County and Milwaukee County EMS are considered covered entities.

As outlined by HIPAA guidelines, covered entity agencies will appoint a designated Privacy Officer and Security Officer to develop, distribute, and enforce policies and procedures for their staff on agency specific privacy and security practices and provide formal HIPAA training for all their staff.

Milwaukee County EMS endorses and expects all EMS Providers working under Milwaukee County Medical Direction to follow their Agency’s internal policies and procedures for privacy and security practices and receive HIPAA training. Any inadvertent, unintentional or negligent act which violates a patient privacy policy must be reported to their Agency’s Privacy Officer.

STEPS to ACHIEVING HIPAA COMPLIANCE:

1. Appoint and Document a HIPAA Compliance Officer
2. Conduct a Risk Analysis
3. Develop/Implement HIPAA Policies and Procedures
4. Train & Appropriately Sanction Workforce
5. Identify Your Business Associates & Enter into Agreements
6. Grant Patients their HIPAA Rights and Distribute Your Notice of Privacy Practices
7. Implement Administrative, Physical and Technical Safeguards
8. Respond Appropriately to HIPAA Violations & Breaches
9. Have a Complaint-Resolution Process
10. Comply with HIPAA Recordkeeping Requirements

HIPAA Resources for Agencies:

Free:

www.hhs.gov/ocr/privacy (U.S. Department of Health & Human Services)

<http://hipaacow.org> (Health Insurance Portability and Accountability Act Collaborative of Wisconsin)

Numerous Documents for Privacy, Security, Risk Toolkit

Privacy 101 Webinar

HIPAA Education ppt slides

Fee based:

www.pwwemslaw.com (The Ambulance Service Guide to HIPAA Compliance, Page, Wolfberg & Wirth law firm)

Complete guide to compliance

Forms and Numerous Policy & Procedure Templates

HIPAA Training DVD

Initial: 4/1/16
Reviewed/revise:
Revision:

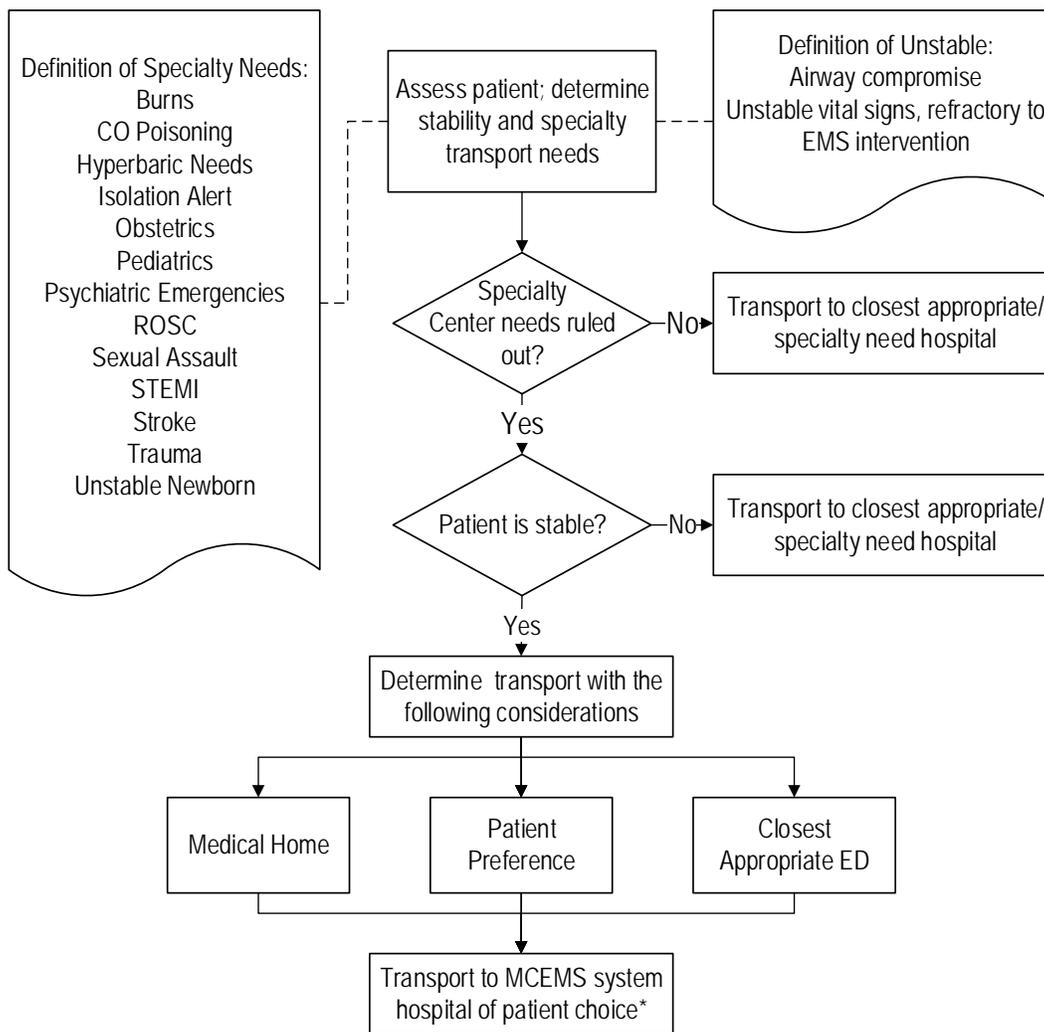
**MILWAUKEE COUNTY EMS
OPERATIONAL POLICY
HOSPITAL DESTINATION**

Approved: M. Riccardo Colella, DO, MPH, FACEP
Page 1 of 1

POLICY: This policy provides principles and decision-making guidance for patients, EMS providers and hospitals within the MCEMS system.

Guiding Principles

- EMS and health care systems will partner to ensure access to safe and high quality care.
- Patients have the right to make informed health choices including hospital destination within the Milwaukee County EMS System; care outside of an informed patient care choice may impact safety, quality and economic risks.



- *EMSystem definition of Internal Disaster: Facility is closed due to internal disaster situation such as physical plant deficiency. In this case, an alternate destination is required.
- Internal Disaster is EMSystem designation recognized by MCEMS as “closing” a hospital to ambulance transport.

Initial: 3/1/16
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Revision:

**MILWAUKEE COUNTY EMS
OPERATIONAL POLICY
LIGHTS AND SIREN GUIDELINES
WITH PATIENT ON-BOARD**

Approved: M. Riccardo Colella, DO, MPH, FACEP
Page 1 of 1

- Use of warning lights and siren is a medical decision.
- Use of warning lights and siren has safety implications to patients, providers and the public.
- Use of warning lights and siren transport to the hospital has little impact on patient care outcome.
- Use of warning lights and siren saves very little time based on scientific literature.
- The provision of ALS care and mode of transport are independent; one does not necessarily determine the other.
- Traffic conditions should not be a determining factor in absence of a truly life-saving or time sensitive emergency.
- Mode of transport is an important tool in developing a culture of patient safety.

POLICY:

The decision to utilize warning lights and siren transport with a patient on-board is a medical decision and will be determined by the judgment of the highest level provider attending the patient.

Warning lights and siren transport may be appropriate with time sensitive conditions (such as Code Stroke, Code STEMI, or patients meeting physiologic or anatomic criteria for Level I/II trauma center transport), impending or obstructed airway concerns not responding to EMS intervention, or other conditions where EMS intervention is unable to manage the patient condition with resources available based on clinical judgment.

Warning lights and siren transport should not be used for patients not described above.

Use of warning lights and sirens will be documented on the patient care record.

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Reviewed/revised: 3/1/16
Revision: 2

**MILWAUKEE COUNTY EMS
OPERATIONAL POLICY
MANAGEMENT OF
DECEASED PATIENTS**

Approved: M. Riccardo Colella, DO, MPH, FACEP
Page 1 of 2

POLICY: Deceased patients will be managed in a professional and respectful manner, to meet the needs of the community, under the guidelines developed in conjunction with the Milwaukee County Medical Examiner's Office.

DEFINITIONS:

Resuscitation attempt: Initiation of basic or advanced life support procedures in an attempt to reverse cardiac arrest of medical or traumatic origin. These procedures include, but are not limited to, CPR, placement of an advanced airway, cardiac monitoring/defibrillation.

Suspicious death: Patient's death is considered to be from other than natural causes, including suspected sudden infant death syndrome (SIDS), crimes, suicide, and accidental death.

Non-suspicious death: Patient's death is apparently due to natural causes.

Potential crime scene: A location where any part of a criminal act occurred, where evidence relating to a crime may be found, or suspicions of a criminal act may have occurred.

PROCEDURE:

Resuscitation will be initiated on all patients in cardiac arrest, unless one of the following conditions is met:

- Decapitation
- Rigor mortis
- Tissue decomposition
- Dependent lividity
- Valid State of Wisconsin Do-Not-Resuscitate order or Physician Orders for Life-Sustaining Treatment
- Fire victim with full-thickness burns to 90% or greater body surface area

A patient may be pronounced en route to a hospital if condition warrants. In such case, the destination should be changed to the Medical Examiner's Office.

A paramedic involved in the resuscitation effort shall call the Medical Examiner's Office to provide a first hand account of the scene and patient history. If no paramedic is on scene, a BLS provider who determines the patient meets criteria for no resuscitation attempt shall place the call.

For a potential crime scene:

- Notify law enforcement if not already involved.
- Include potential crime information in report to Medical Examiner's Office.
- Observe, document and report to law enforcement anything unusual at the scene.
- Protect potential evidence
 - Do not "clean up" the body
 - Leave holes in clothing from bullet or stab wounds intact
 - Do not touch or move items at the scene
 - Observe, document and report to law enforcement and the Medical Examiner's Office any items disturbed by EMS at the scene
- Turn the body over to law enforcement
- Law enforcement has the legal responsibility to maintain scene integrity

Initial: 10/14/09
Reviewed/revised: 3/1/16
Revision: 2

**MILWAUKEE COUNTY EMS
OPERATIONAL POLICY
MANAGEMENT OF
DECEASED PATIENTS**

Approved: M. Riccardo Colella, DO, MPH, FACEP
Page 2 of 2

For all other patients:

- Do not remove lines or tubes from the deceased
- Do not “clean up” the body
- Do not disturb the scene
- If covering the body, use only a clean, disposable blanket

Disposition of the body:

- Do not leave the body unattended
- The body may be turned over to law enforcement, which has the legal responsibility to maintain scene integrity
- If approval is granted by the Medical Examiner’s Office, the body may be turned over to a funeral home
- If the resuscitation attempt took place in the ambulance, include the information in your report and transport to the Medical Examiner’s Office at 933 West Highland Avenue
 - Do not transfer the body to another transport vehicle unless the municipality would be left with no available responding ALS unit; refer to individual municipal policy
 - If the death is considered suspicious, a police officer or detective may accompany the body in the ambulance to the Medical Examiner’s Office to maintain integrity of evidence
- Transport to a funeral home shall be determined by individual municipal policy

Documentation:

A patient care record will be completed for all expired patients. Documentation will include:

- Pertinent information regarding patient’s known medical history.
- Treatment provided; if no treatment was provided, the reason for not initiating a resuscitation attempt.
- The time of determination not to initiate resuscitative measures, or the time CPR was discontinued

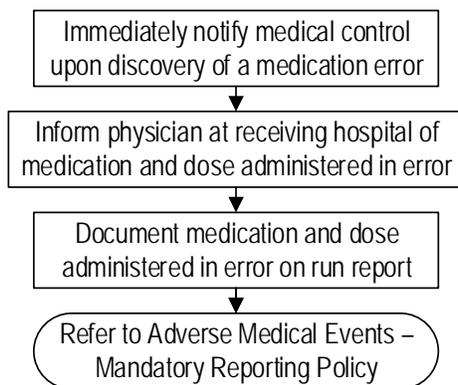
A copy of the patient care record is to be forwarded to the Medical Examiner’s Office.

Initiated: 12/10/82
Revised: 3/1/16
Revision: 5

**MILWAUKEE COUNTY EMS
OPERATIONAL POLICY
MEDICATION ERRORS**

Approved: M. Riccardo Colella, DO, MPH, FACEP
Page 1 of 1

POLICY: In circumstances where a medication error is made, appropriate personnel must be notified immediately upon discovery of the error.



Initial: 3/1/16
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**MILWAUKEE COUNTY EMS
OPERATIONAL POLICY
ON-LINE MEDICAL CONTROL
(OLMC) GUIDELINES**

Approved: M. Riccardo Colella, DO, MPH, FACEP
Page 1 of 1

POLICY:

Milwaukee County EMS Advanced Life Support providers will establish on-line medical control whenever:

- Directed by the MCEMS Standards and Practice (S&P) Manual
- Special circumstances not specifically outlined in the S&P manual arise, requiring emergent medical advice, opinion, or orders
- Deteriorating patient conditions do not improve with protocols

Circumstances may arise where there is an inability to carry out an OLMC order, e.g. the provider feels the administration of an ordered medication would endanger the patient, a medication is not available, or a physician's order is outside the protocol:

- The prehospital provider must immediately notify the consulting physician why the order cannot be carried out
- The prehospital provider must initiate the MCEMS Quality Assurance process as soon as practical following the call (same shift) by calling the EMS Incident Line at (414) 257-6660.

Circumstances may arise where the OLMC physician provides orders for extraordinary care. In rare cases, a physician providing on-line medical consultation may direct a prehospital provider to render care that is truly life-saving, not explicitly listed within the protocols, but within the Wisconsin EMS Scope of Practice guidelines for the provider's level of EMS licensure:

- During the consultation, the physician and prehospital provider must acknowledge and agree that the patient's condition and extraordinary care are not addressed elsewhere within these medical protocols and the order is absolutely necessary to maintain the life of the patient.
- The prehospital provider must feel capable of correctly performing the care directed by the consulting physician, based on the instructions given by the consulting physician.
- The prehospital provider must inform the consulting physician of the effect of the treatment and notify the receiving physician of the treatment upon arrival at the hospital.
- The prehospital provider must initiate the MCEMS Quality Assurance process as soon as practical following the call (same shift) by calling the EMS Incident Line at (414) 257-6660.

Circumstances may arise where the prehospital provider may not be able to contact an OLMC physician because of a radio or other communication failure:

- The prehospital provider must attempt to contact the MCEMS EMSCOM center by direct telephone.
- The prehospital provider must provide care as outlined in the S&P manual.
- The prehospital provider must not provide care exceeding the training certification or scope of care of the EMS provider as outlined by the MCEMS Operational Plan or State of Wisconsin EMS guidelines.

Care under exceptional circumstances (mass casualty or other disaster) will be addressed in a separate policy/guideline.

Initiated: 3/1/16
Reviewed/revise:
Revision:

**MILWAUKEE COUNTY EMS
OPERATIONAL POLICY
POLICE BODY-WORN CAMERAS /
VIDEO RECORDINGS**

Approved by: M. Riccardo Colella, DO, MPH, FACEP
Page: 1 of 1

PURPOSE: Body-worn cameras (BWC) will be used by the Milwaukee Police Department and the Milwaukee County Sheriff's Office beginning September 2015. Additional law enforcement agencies will likely add these devices in the future. They are used to assist Officers in the performance of their duties by providing an accurate and unbiased recording of interactions between police members and the public.

INFORMATIONAL: During the course of activation, these recordings may also capture EMS patient activities. The recordings are owned by the law enforcement agency and therefore are subject to the Wisconsin Open Records Law. Law enforcement agencies are not considered covered entities under HIPAA or covered by Wisconsin patient health care confidentiality laws. Milwaukee County Corporation Counsel's opinion was requested concerning EMS rights and police body-worn cameras. Their opinion is outlined below.

1. EMS may not impede law enforcement duties by activation of BWC by citing HIPAA or other concerns.
2. By necessity, confidentiality issues must be addressed after the fact for those occurrences.
3. Where a patient is receiving medical care and does not pose a likelihood of immediate law enforcement intervention, EMS could request that the officer de-activate the BWC. However, this is dependent upon the severity of patient's medical condition and the officer's judgement of whether circumstances merit activation of the BWC, including the potential that the person may abscond.
4. If the patient is in custody and being investigated, EMS cannot and should not intervene in law enforcement duties regarding activation of the BWC.
5. Both MPD and MC Sheriff's Office have policies in place to address privacy issues. MPD states BWC's will not be activated "in a place where a reasonable expectation of privacy exists..." and accidental recording may be deleted before the retention period expires at the Chief's discretion. The MC Sheriff's Office policy contains a provision for deletion requests as well.

RECOMMENDATIONS:

1. Perform EMS business as usual.
2. Apply safety precautions first.
3. Protect the patient's privacy, if able. Currently if sensitive patient healthcare issues need to be discussed, EMS may ask the Officer to step away for privacy. Continue to do so, however, the Officer always has the discretion to comply or not.
4. Any EMS event may potentially be recorded by the public as well, necessitating professionalism at all times.
5. Quality documentation is more important than ever in caring for your patient as well as protecting yourself.